Injury Control Update

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Smoking out barriers to fire prevention

Sirens screamed and lights flashed as fire trucks drove through the streets of a low-income housing area of Oklahoma City. Despite the appearance, the trucks were not rushing to a four-alarm fire. Instead, they were out to promote fire prevention. To bolster the effort, volunteers walked alongside the fire trucks and handed out free smoke detectors to area residents.

In all, the Oklahoma City LifeSavers project gave out 10,100 smoke detectors to households that needed them. As important, the program emphasized maintaining the smoke detectors to be sure they continued working over months and years.

LifeSavers was the first program of its type to use surveillance data to evaluate its effectiveness, according to Sue Mallonee, RN, MPH, of the Injury Prevention Service at the Oklahoma State Department of Health. As a result, this NCIPC-sponsored program has given concrete evidence of the value of smoke detector programs.

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Injury prevention enters the emergency department

The gurney bursts through the emergency department doors, and EMS technicians race the bloodied patient to the exam room, barking out as they go: "Car crash—chest wound—deep lacerations to the head—BP 100 over 60!" Emergency medicine doctors and nurses rush to meet the arrival, responding to their latest crisis with intensity and practiced professionalism.

Just another scene from "ER," one of network television's hit shows, which draws some 30 million viewers every week. And just another scene repeated daily at hospital emergency departments (EDs) across the country, where crisis response is routine.

This frenetic environment, with its emphasis on immediate treatment of people in urgent need, may at first seem an unlikely place for injury surveillance and prevention efforts. In fact, the ED is emerging as an important nexus between

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U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

CDC CENTERS FOR DISEASE CONTROL AND PREVENTION

CDC's director shares his vision of Safe America

Dr. David Satcher, MD, PhD, director of the Centers for Disease Control and Prevention, supports a comprehensive approach to injury prevention and control that is encompassed by the concept of a safe America. He recently talked with *Injury Control Update* editors to help translate the concept into concrete ideas and activities.

Q: *NCIPC is proposing a new initiative entitled "Safe America." What is your vision of a safe America?*

A: I think of an America that has in place all the *systems* necessary to keep people safe. That includes being safe on the highway; being safe in the home, from fires, for example; being safe in communities from all kinds of violence, especially that perpetrated with guns. What are the systems we need to have in place? Environmental systems, trauma care systems to reduce the impact of injuries, social systems that give people hope for the future, and individual support like training programs for parents.

> ***"If public health doesn't work at the level of the community, it doesn't work."***
>
> — David Satcher, MD, PhD
> Director
> Centers for Disease Control and Prevention

If public health doesn't work at the level of the community, it doesn't work. It can be happening at CDC, but it will make no difference unless it works in the community. Safe America means protecting people in their homes, schools, communities, in all their interactions.

Q: Part of the Safe America proposal involves initiating concrete interventions at the community level. Do we have a solid enough scientific base to be implementing these interventions?

A: Yes, we know a lot, especially in the area of unintentional injury. We have good information on keeping people safe in automobiles, in homes, on playgrounds, and at work. We are not adequately utilizing the knowledge we have.

But even though we know a lot, we still need to know more. The public health approach is a continual process, a cycle. Public health proceeds from surveillance. We first ask questions in an attempt to define the nature and magnitude of the problem. We have been working hard to implement surveillance for injury. Next we try to identify risk factors—why some people are more likely than others to be victims of fires, suicide, homicide, and other kinds of injuries. We go from there to introduce interventions. We have recently completed demonstration projects in youth violence prevention in 15 cities. Once we know the outcomes of the interventions, we will be able to say that we know what things work and that we should implement them more widely. Then we go back and ask more questions.

Q: You mentioned that we know a lot in the area of unintentional injuries: can you mention a few interventions that you believe really make a difference?

"Safe America means protecting people in their homes, schools, communitites, in all their interactions."

A: Bicycle helmets, for one. We know they make a positive difference, but people still ride bicycles without helmets. Other obvious interventions that are not being taken advantage of are automobile safety seats for children and smoke detectors. In1995, 26% of U.S. homes were without functional smoke detectors; the percentage is higher in some communities. So we know of many interventions that work, and yet people are not adopting them.

We also know a good deal about what puts people at risk for intentional injury, even though some of these issues are very sensitive politically. For example, we know a lot about the relationship between guns and suicide and between guns and homicide. We know that suicides have tripled among teenagers since 1950, and that at least 75% of that increase is associated with firearms. We know that homicide among teenagers has tripled since 1980, and that 90% of that increase is associated with firearms. We need to get firearms out of the hands of children.

Q: What about the public's awareness of injuries as a serious public health problem? Is there still a perception that injuries are "accidents," that they're inevitable and not preventable? What would you say to people with that perception?

A: I believe many people have not gotten to the point of thinking of injuries as public health problems, and they don't necessarily see them as preventable. We still have 200,000 traumatic brain injuries and 80,000 spinal cord injuries in this country every year; most of those are preventable. The role of public health is not only to define the magnitude of the problem and to identify who is at risk, but also to demonstrate that injuries can be prevented and to show people how to prevent them. We have found some interventions that work, and where we've done that, I think we need to communicate it better.

Q: *How important are partners in CDC's vision of a safe America?*

A: Partners are critical. The future of public health depends on our ability to develop new partnerships, especially at the level of the community. The only way we can get interventions to the people who need them is to find natural partnerships within communities.

We also have to have partners at the national level. The Department of Justice and the National Highway Traffic Safety Administration are important partnerships. So are the Consumer Product Safety Commission and the Department of Housing and Urban Development.

Q: *In this era of belt-tightening and budget-cutting, why should injury be a priority?*

A: In a time of downsizing and fiscal constraints, it's especially important to make wise investments. I think injury prevention represents a good investment of public funds. When we can prevent human pain and suffering, we've made a good investment. It's also a good financial investment. This is a country in which injuries cost us more than $150 billion a year in direct and indirect costs. We can prevent a lot of that cost if we invest in injury prevention and control. The issue is where to invest limited resources. I would say it's best to invest where you have the greatest impact in terms of reducing pain and suffering and in terms of reducing costs in the health care system and beyond.

Q: *Children and older adults seem to be most affected by injuries.*

A: Yes. For example, the most recent Surgeon General's report noted that physical activity can help prevent the 240,000 hip fractures we have in the country every year by encouraging older people to exercise and to improve their strength and flexibility. NCIPC is also looking at other interventions to reduce hip fractures and falls among the elderly. We spend a lot of money on medical care to treat hip fractures and injuries resulting from falls; we could save considerably if we invested more in front-end research to prevent these injuries from happening.

The elderly are often victims of fires and, increasingly, of abuse. When we investigated all the deaths related to heat two summers ago in Chicago, we found that many elderly people had their windows nailed shut for security reasons. In addition to the heat and the lack of air conditioning, fans didn't even help because the windows were closed.

Q: *Do you have any final comments about Safe America?*

A: I'd like to stress the importance of fostering a global perspective. We're dealing with so many issues at CDC that have global implications. Injury is one of these. As America becomes safer for America's people, it will also become safer for other people. To the extent that we teach children how to resolve conflicts in their communities, they will grow up with an orientation that helps them resolve global conflicts. Without a safe America, the United States cannot play its role in making the world a safer place to live. ■

Injury Journal Club

Schnitzer PG, Runyan CW. Injuries to women in the United States: an overview. Women and Health 1995;23(1):9-27.

The heavy toll that injuries take on young men is frequently in the news. What may be less heralded is injury's impact on women. In fact, injuries are the leading causes of death for women under the age of 34 and are responsible for more years of potential life lost before the age of 65 than any other cause of death. This article summarizes gender-specific injury information, drawing on 1984-1988 mortality statistics from CDC's National Center for Health Statistics and information from a decade of studies. Overall, the most significant injury problems for women are motor vehicle-related injuries, falls, and violence, especially domestic assault.

Malliaris AC, DeBlois JH, Digges, KH. Light vehicle occupant ejections—a comprehensive investigation. Accid Anal and Prev 1996;28:1-14.

Being thrown, or ejected, from a vehicle as a result of a crash is an infrequent incident (about 1.5% of all occupant events), but a very harmful one. This study examined a range of variables relating to occupant ejections from "light vehicles"—cars, pickup trucks, vans, and utility vehicles. A key finding was that people who used some type of restraint, primarily safety belts, had sharply lower rates of injury than those who did not use safety belts. However, there is an apparent disparity between the substantial overall increase in safety belt use over the past decade and the absence of any reduction in occupant ejections. This finding suggests that many "high-risk" occupants involved in crashes that lead to ejections are still not wearing safety belts.

Tellez MG, Mackersie RC, Morabito D, Shagoury C, Heye C. Risks, costs, and the expected complication of re-injury. Am J Surg 1995;170:660-4.

Violence tends not to be a one-time event. Young people treated for violent injuries at a San Francisco trauma center had a 16% rate of prior injuries, virtually all of them within the previous 5 years. The youths were victims of gunshot wounds, assault, and stab wounds, with gunshot wounds being the major cause of injury (44%). The authors note, "As surgeons, we would consider a 16% recurrence rate unacceptable in common operations and disease entities." Trauma registries can complement data gathered by criminal justice agencies, to give a fuller picture of how to reduce violence recidivism.

Massagli TL, Michaud LJ, Rivara, FP. Association between injury indices and outcome after severe traumatic brain injury in children. Arch Phys Med Rehabil 1996;77:125-31.

Children who suffer a traumatic brain injury (TBI) can benefit from a range of rehabilitation services. To identify the most appropriate services and to predict the likely outcomes for these children, health care professionals use various scales to assess the child's level of functioning after injury. This study examined the outcomes of children 5 to 7 years after discharge from the hospital to learn about any persisting disabilities and to find out if the assessment instrument (Glascow Outcome Scale) was accurate in predicting their recovery. The study found that it was difficult to measure future outcomes at the time the children were discharged from the hospital; almost half of the children thought to have a good chance of recovery later had moderate disability and problems in a number of areas, including education and jobs. Also, many of the children in this study were not continuing to receive important medical, neurological, or social follow up. ■

SMOKING (continued)

In the five years following the study, the rate of injuries and deaths from fires in the target area declined 73%. During the same period, the rate for the rest of the city increased 30%. A year after the giveaway program, more than half of the smoke detectors were still working, and four years later, 45% were functional. Further, the study showed that for every $1 spent on the giveaway program, $20 was saved in medical costs.

Concentrating on populations at highest risk

In the rest of the United States, as in Oklahoma City, the people at greatest risk for fire-related injury and death are young children and the elderly, both of whom may be unable to move quickly if they need to escape from smoke and flames. For children under 5 years old, the risk of dying in a house fire is twice as high as for the rest of the population. Also, fatal house fires are all too common in low-income neighborhoods, where people are unlikely to have smoke detectors.

A large number of the 12% of American households without smoke detectors installed have annual incomes below $15,000. Yet smoke alarms are inexpensive, simple to install, and cost-effective. Giveaway programs targeted at high-risk areas—like the LifeSavers Program in the inner city of Oklahoma City—should help get smoke detectors into these homes.

Installing smoke detectors not enough

Programs to give away and install smoke alarms provide only a partial solution, however. An observational study by the Consumer Product Safety Commission (CPSC) found that 26% of households with smoke detectors were not adequately

protected because they did not have a functional detector on every level. While 11 million U.S. households are without smoke detectors altogether, an even greater number—16 million—have non-working detectors. These alarms have dead, corroded, or missing batteries, or they have been disconnected because of nuisance alarms.

"16 million American homes have nonworking smoke detectors."

To examine the problem of nonworking smoke detectors, CPSC initiated a task force in 1989 that has grown into a public-private partnership of 200 organizations, including manufacturers and safety organizations. When they completed deliberations in June 1996, the group recommended to the Underwriters' Laboratory Voluntary Standards (ULVS) ten criteria for improving the reliability of smoke detectors. One of these is a silencing button that will allow people to turn off a smoke alarm for 15 minutes, so they won't disable it in frustration when they are cooking.

By identifying and then publicizing the problem of nonworking smoke alarms, the task force challenged industry to develop solutions. Equipment that meets safety and performance standards earns ULVS approval, a certification highly regarded throughout the industry, and manufacturers have risen to the challenge. One recently developed product is the 10-year lithium battery, a major solution to the problem of dead batteries and the need to change them frequently.

James F. Hoebel, Chief Engineer for Fire Safety at CPSC, credits the success of this public-private effort to the dedication and cooperative spirit within the task force. "All involved parties were working toward a common goal," says Mr. Hoebel, "and all of us thought the work was worth doing."

Federal partners fight fire-related injuries

Fruitful collaboration is the essential ingredient in another recent fire-injury prevention effort, says Dr. Christine Branche, Director of NCIPC's Division of Unintentional Injury Prevention.

Several of the federal partners in the Healthy People 2000 Unintentional Injury Work Group approach fire-injury prevention from different angles. The National Fire Protection Association has developed the Learn Not to Burn™ preschool curriculum to teach young children about fire safety. The U.S. Fire Administration (USFA) trains firefighters, makes fire department personnel available to inspect homes and install smoke alarms, and sponsors awareness programs such as Change Your Clock, Change Your Battery. Working with USFA, the Indian Health Service established the National Safe Home Coalition, which concentrates on reducing fire-related trauma in Native American communities. The Administration on Aging has developed Let's Retire Fire: A Fire Safety Program for Older Americans.

The National SAFE KIDS Campaign, another of the working group partners, worked with more than 200 state and local coalitions to develop Project GET ALARMED: A Residential Fire Detection Strategy. The project focuses on educating parents and raising public awareness about the importance of smoke detectors, on advocating for strong state laws on smoke detector use, and on installing and maintaining alarms in homes of low-income families with young children. SAFE KIDS is targeting Mississippi and Missouri in particular, because of the high residential fire mortality rates in these states.

In addition to fostering collaboration, the Healthy People 2000 Unintentional Injury Work Group recommends that states and localities develop community-based partnerships. According to Dr. Branche, programs designed by the community lead to better strategies for distributing smoke alarms and give communities a vested interest in the outcomes. The work group encourages communities to direct their programs to older adults as well as to children, because people 65 and older are a high-risk group often neglected by residential fire prevention programs.

State programs benefit children, elderly

NCIPC is now working with five states—Arkansas, Kansas, Maryland, Minnesota, and Oklahoma—to reduce fire-related burn injuries and deaths among children and adults. These states are establishing surveillance systems to monitor the prevalence of smoke detectors in homes and are developing and evaluating interventions to increase the number of working smoke detectors.

Arkansas' program is an example of a state-based intervention to provide smoke detectors to the elderly and to low-income families with young children. The program reached children through Head Start, but Dr. David Bourne, Medical Director of the Preventive Health Section in the Arkansas Department of Health, said that reaching the state's elderly residents presented a unique challenge.

After finding that many of the Arkansas elderly were alone and unwilling to open their doors, the department staff decided to approach them through organized day centers and volunteer fire departments. Dr. Bourne adds that an advantage of using fire department volunteers is that once inside a home, they can look for other obvious health risks. For instance, many elderly people have inadequate ventilation against the oppressive summer heat because they nail their windows shut, or they may have throw rugs scattered about, which increases the likelihood of falls.

With the graying of the U.S. population, says Dr. Bourne, increasing attention and resources must be devoted to the special health and safety risks of older Americans. It is easy to underestimate their potential isolation: surprisingly, not one retiree who attended the health department's fire injury prevention session at one senior center had ever seen or even heard of a smoke detector. ■

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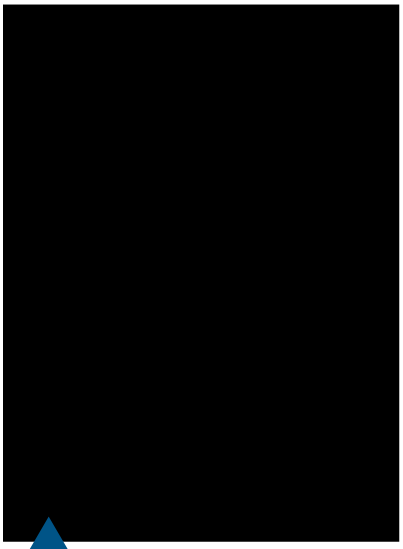
New appointments round out NCIPC top management team

With the recent selection of two new division directors, NCIPC has its top management team in place, according to Director Mark L. Rosenberg, MD, MPP.



CDC Staff photo

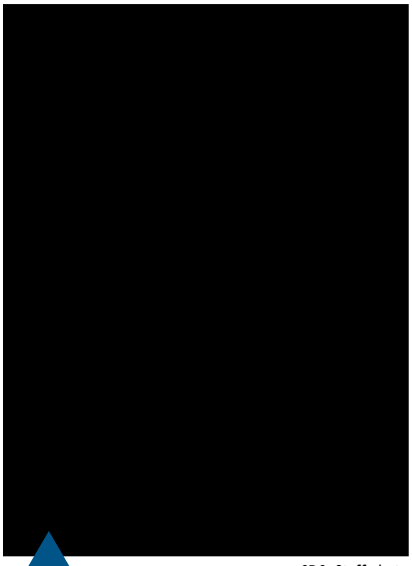
Dr. Christine Branche recently took over leadership of NCIPC's Division of Unintentional Injury Prevention. The division's focus is on injuries related to motor vehile crashes and home and leisure activities.

Christine Branche, PhD, now heads the Division of Unintentional Injury Prevention (DUIP), and Rodney Hammond, PhD, is the new director of the Division of Violence Prevention. Continuing as director of the Division of Acute Care, Rehabilitation Research, and Disability Prevention is Richard J. Waxweiler, PhD.

Dr. Branche brings extensive experience in the field of injury prevention to her new position. She became an Epidemic Intelligence Service (EIS) officer in the Public Health Service in 1988, choosing injury epidemiology and control as her area of focus. Her scientific work in the field has included research on drowning, spinal cord injuries from water recreation, falls among the elderly, and occupational injuries.

The new division director has worked extensively with injury professionals, both within CDC and nationally. Dr. Branche has been team leader of DUIP's Home and Leisure Injury Prevention Team and also headed the work group in that area in the national agenda-setting process for injury prevention and control. She currently leads CDC's working group to review progress toward the Healthy People 2000 Objectives in reducing fire-related injuries.

Dr. Hammond brings to CDC a solid grounding in academic research and community-level programming in violence prevention. His work on prevention of youth homicide and suicide has won both professional awards and media attention. Until his recent move to NCIPC, he was director of the Center for Child and Adolescent Violence Prevention in Dayton, Ohio. He developed PACT (Positive Adolescent Choices Training), a school-based early intervention program, and he is author of the series, *Dealing with Anger: A Violence Prevention Program for African-American Youth.*



CDC Staff photo

As the new director of NCIPC's Division of Violence Prevention, Dr. Rodney Hammond leads work in youth violence, including suicide, and in family and intimate violence.

At Dayton, Dr. Hammond was associate professor in the School of Professional Psychology at Wright State University, and he formerly was an assistant professor of psychiatry and director of children, youth, and family services at Meharry Medical College in Nashville, Tennessee. He is a Fellow of the American Psychological Association and a member of the Presidential Task Force on Violence and the Family.

Dr. Waxweiler directed CDC's 2-year process to shape a national agenda on injury prevention and control, which culminated in recommendations published as *Injury Control in the 1990s: A National Plan for Action* and a series of professional publications. ■

INJURY (continued)

clinical care of injuries and the broader quest for underlying risk factors for those injuries and ways to prevent them.

Pushing the boundaries of the ED

"There's no question that if you have 150 patients a day, your priority is treating one patient and moving on to the next crisis," acknowledged Jeffrey H. Coben, MD, director of the University of Pittsburgh Medical Center's Center for Injury Research and Control (CIRCL). "Making the initial diagnosis and providing speedy care are the core of emergency medicine, and there are real constraints in terms of time and the acuity of patients' injuries or illnesses."

But people in the field who deal with injuries day in and day out are interested in doing more than just patching up the wounded and moving along, he said. "Nothing motivates you more to do something about preventing the toll of injuries than having to break the news to a family about a relative's death from a car crash or gunshot wound."

Most injuries that cause a significant number of deaths are treated in EDs, and from 25% to 40% of all hospital ED visits are for care of injuries, ranging from the minor to the life-threatening. Many of these injuries are related to problems that are recurrent and escalating in nature, such as domestic abuse and alcohol-related car crashes. Such a pattern of injury, plus the fact that the ED is the only place many people go to seek care, makes it potentially an ideal point of intervention.

"The ED often is the only opportunity to identify people with these problems and to intervene," said Rick Waxweiler, PhD, director of NCIPC's Division of Acute Care, Rehabilitation Research, and Disability Prevention. He said that the ED is a key element in the ideal trauma system's continuum of care, which begins with prehospital care, such as response from emergency medical services, and moves on through ED care, inpatient hospital care, and rehabilitation.

ED data—mining a valuable resource

Unfortunately, much of the information that could make it possible to intervene is not readily available. "In the traditional paper-based information approach of most clinical services, records get archived and are virtually inaccessible," said Dan Pollock, MD, MPH, who leads the Acute Care Team in the division.

As a result, we miss the opportunity of mining ED data for insights into the health care needs not only of people treated in the ED, but also of the community. Most injuries are not fatal and may not even require hospitalization, but the data we have to work with are from death certificates, medical examiner databases, and trauma registries. "Focusing on this incomplete and nonrepresentative set of injuries," say Dr. Herb Garrison and colleagues in a 1994 issue of *Annals of Emergency Medicine*, "reduces the validity of the data and limits a full assessment of preventive and therapeutic interventions."

Standardized, easily accessible data also have other advantages. Making ED data more comparable and accessible will increase its value for such applications as quality assurance, research, and training. Because the information will help define ways to prevent injuries, there is also the possibility of dramatic savings in health care costs.

To put ED data in a form that will be most useful both to ED staff and for defining community patterns of injury and illness, NCIPC has spearheaded efforts to standardize and consolidate all ED data—not just injury-related data. Partners in this surveillance initiative include the American College of Emergency Physicians (ACEP), the Society of Academic Emergency Medicine (SAEM), the American Trauma Society, the National Association of State Emergency Medical Services Directors, and other groups.

In January 1995, NCIPC convened a meeting to develop recommendations for standard data elements to be used in coding information for an electronic data base for EDs. A committee of ED physicians, nurses, and information specialists revised the initial draft of *Data Elements for Emergency Department Systems* (DEEDS). NCIPC expects the report to be available in summer 1997.

Barriers to change

Even though ED staff may appreciate the potential of taking the longer view on ED data, what about the pressure-cooker environment that characterizes most EDs? How can harried emergency medicine professionals add one more activity to their role?

Part of the solution is to bring in other professionals whose expertise and focus on surveillance and prevention activities can complement the core ED staff. For example, social workers and counselors in domestic violence help identify and intervene with patients' problems (see accompanying article on page 12).

The goal in surveillance is to make the information-gathering task as easy as possible for the time-pressured medical and nursing staff. "We try to rely on

Photo courtesy of the Grady Health System

The words "emergency department" raise visions of frenetic activity, aimed at treating people whose lives are in the balance. But the ED is also emerging as a hub for injury surveillance and prevention efforts.

data they are already collecting as part of the clinical care of patients," explained CIRCL's Dr. Coben. "We try not to be intrusive about asking staff to fill out additional forms or take extra steps. The reality is, the ED is a busy place."

Injury surveillance in today's EDs

Despite the absence of a nationwide ED information system, selected surveillance efforts are underway in some areas. For example, several hospital EDs are gathering information on nonfatal firearm injuries. One site is Froedpert Memorial Lutheran Hospital in Milwaukee, where Steve Hargarten, MD, an associate professor of emergency medicine at the Medical College of Wisconsin, directs surveillance.

"Emergency physicians see and treat millions of injuries each year in the United States," said Dr. Hargarten. "One aspect of managing these injuries from a public health perspective is to take advantage of surveillance in the ED."

Interest in surveillance and prevention of injury is rising, said Dr. Hargarten, who is on SAEM's task force on ED surveillance. He points out that a decade ago, there was virtually no interest in injury control, and today, ACEP has an injury control section with more than 100 members, SAEM has been active in stimulating injury research, and the *Annals of Emergency Medicine* regularly publishes articles on injury topics.

Pittsburgh's CIRCL is also focusing on ways to capture ED data. As part of a wider surveillance effort to define the extent of the injury problem in the state, CIRCL is working with EMS providers to gather population-based information on injuries they record. Part of the research center's project emphasizes making these injury data available to the public health community. A natural language computer program makes it easy for injury control practitioners to access the EMS data base to obtain information on which to plan prevention strategies.

Opportunities for primary prevention

In its work, CIRCL also encourages EMS responders to practice primary injury prevention. "If a paramedic goes to the home of an elderly person to transport him to the hospital, there's no reason why the paramedic couldn't do a quick home assessment—check for risk factors for fire or falls," said Dr. Coben. "There's a real opportunity for paramedics to be an extension of the emergency care providers into the community."

For emergency care nurses in the nation's hospitals, injury prevention has also become a priority. The Emergency Nurses Association (ENA), with a membership of more than 25,000 registered nurses who specialize in emergency care, has recently established a national committee to look at the issue of injury prevention.

Laurie Flaherty, RN,MS, CEN, project coordinator of ENA's injury prevention grant, explained the emphasis on prevention in personal terms. After awhile, she said, the adrenalin rush that often drives emergency medicine professionals is overcome by frustration at seeing one preventable injury after another. Too often, they see the consequences of kids riding in cars without seat belts or kids riding in the back of a truck.

"We all have stories of people who've died or had their lives changed forever as a result of injuries that were completely preventable," said Ms. Flaherty. "That's what ED staff can bring to the issue of prevention in a way that others in the field can't: we can put a face on the tragedy of preventable injuries." ■

Unique program involves EDs in helping victims of domestic abuse

Photo courtesy of WomanKind

WomanKind founder and director Susan M. Hadley, MPH, and David Justis, MD, counsel a woman at an emergency department in the Fairview Health System.

When an abused woman walks through the doors of the emergency department (ED) to seek treatment for physical injuries or medical symptoms, she may be taking the first step in a journey to rebuild her life.

Even women who come to the ED with so-called "minor" injuries may be reaching out. A traditional response might be to downplay the injuries, or even—in response to managed care pressures—chastise the patient for seeking an inappropriate level of care, without recognizing the signs of abuse or an indirect plea for help.

However, an increasing number of hospitals throughout the country are beginning to appreciate that EDs are ideal sites to identify and help women who are in abusive relationships. A pioneer in this field is WomanKind, a hospitalwide domestic abuse program, offering around-the-clock case management and advocacy services at three Minneapolis-area hospitals, including crisis intervention and ongoing assistance to women who suffer from physical, sexual, or emotional abuse.

The encounter between an abused woman and an ED staff person represents an important "teachable moment," a type of early intervention that can make a big difference, according to Susan M. Hadley, MPH, founder and director of WomanKind. Started 11 years ago as a nonprofit organization to provide domestic abuse counseling services in the ED on a contract basis, WomanKind today is a department of the Minnesota-based Fairview Health System, serving an average of more than 100 new clients each month, including women in some inpatient units and numerous referrals from medical offices in the community.

Building on the teachable moment

Although domestic abuse prevention efforts are expanding to clinics and doctors' offices, the ED remains the focal point for reaching women with a violent home life who are seeking help, even indirectly. In the past, busy ED staff haven't always recognized the problem or known how to respond. The warning signs may be too subtle, the cause of the injuries may masquerade as something else ("I walked into a door"), and the woman may be too ashamed or afraid to acknowledge the real problem. If abuse

does become apparent, staff may react in a judgmental manner or may counsel an inappropriately precipitous action, such as leaving the abuser immediately.

Enter WomanKind. If an ED clinician identifies a potential abuse victim, she offers to contact WomanKind on the woman's behalf. Within 30 minutes of such a request from an ED physician or nurse, a WomanKind volunteer arrives at the hospital, provides support and information for the woman during her entire stay, helps craft a safety plan if the patient decides to return to her home, and sets up a time for a WomanKind staff person to make a follow-up call or visit. The WomanKind staff maintain contact with the woman and help her examine both short- and long-term goals and options.

WomanKind training emphasizes that ED counseling is, ideally, *early* intervention and that many women are not ready to take the major step of going to a battered women's shelter. "It's a major life decision for a woman to contemplate leaving an abusive partner," explained Ms. Hadley. "And like all major life decisions, it's a process. It may take a woman weeks or months or even years to work through that process. The woman is the 'expert' on what's right for her, and health professionals need to respect her process and decisions."

Understandably, ED clinicians' orientation is to "fix" patients, but such expectations may be unrealistic in the context of domestic abuse. "Often, ED staff feel that they have failed if the abused woman returns to her relationship. Our training encourages staff to redefine 'success'—that is, the encounter has been successful if the woman begins to feel a sense of support and safety in the health care setting, if she begins to talk about the abuse, if she leaves the ED with a sense of having choices. WomanKind's counseling aims to reduce the woman's sense of isolation and help her reorient her thinking so that she can break down what seems like an insurmountable problem into concrete steps."

Working within the system

Staff training is an integral component of WomanKind's success. New nurses in all departments in the Fairview System hospitals and clinics get basic orientation in domestic violence prevention, and continuing in-service sessions reinforce the message. Other key elements are policies and protocols that aim to make domestic violence assessment and intervention a routine part of patient care. For example, the Fairview abuse prevention plan is used to assess each patient for possible abuse and specifies the actions taken, including referral to WomanKind.

> ***"The encounter between an abused woman and an ED staff person is an important "teachable moment," an early intervention that can make a big difference."***
>
> – Susan M. Hadley, founder and director, WomanKind

Being "in the loop" is critical, Ms. Hadley said. "If you're not part of the hospital's system, not part of the lines of referral and communication, you may not get called until the situation gets critical." She worked hard to win the hospital staffs' trust, acknowledging that some clinical staff initially resisted the idea of bringing volunteers into a high-stress ED. "It was not a turf issue," she pointed out. "ED doctors and nurses are wonderful—intelligent, independent, activist—and

they really care about their patients. We had to prove ourselves to them, show that we'd be there when we said we would and that we could provide another facet of care for their patients."

For more information....

• Contact Susan M. Hadley (612/924-5775) for information or samples of materials, including the WomanKind reference card series to help health professionals assess women for abuse problems, the Fairview abuse prevention plan, and a card summarizing an eight-step approach to supporting a woman who is being abused.

• A book by Ms. Hadley, *The Health Professional's Guide to Domestic Abuse*, will be published soon by the Fairview Press. It addresses signs and symptoms, assessment, intervention, documentation, safety issues, legal liability of health professionals, and requirements of the Joint Commission on Accreditation of Health Organizations.

• For a detailed description of the program, see "WomanKind: An Innovative Model of Health Care Response to Domestic Abuse," in *Women's Health Issues*, Vol. 5, No. 4, winter 1995. ■

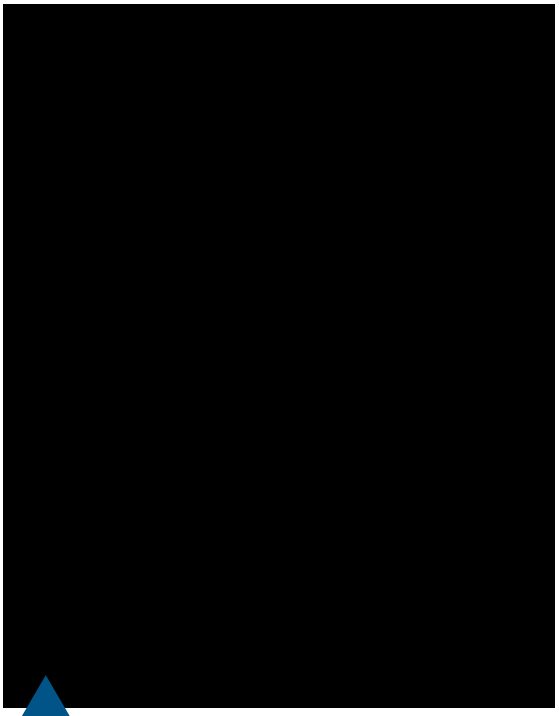


Photo courtesy of WomanKind

WomanKind recommends these eight steps for supporting a woman who is in an abusive situation.

Resources You Can Use

Several new publications are available from the National Center for Injury Prevention and Control. They can be ordered through NCIPC's Internet home page: http://www.cdc.gov/ncipc/ncipchm.htm or by writing to NCIPC, Attention: Library Desk, MS K-65, 4770 Buford Highway, NE, Chamblee, GA 30341-3724.

Home and Leisure Injuries in the United States assembles in one publication articles that appeared in CDC's *Morbidity and Mortality Weekly Report (MMWR)* between 1985 and 1995. The decade's collection includes reports on unintentional injury surveillance and the economic impact of unintentional injury as well as cause-related information on injuries from residential fires, sports and leisure activities, and poisoning. This compendium of articles underlines the seriousness of unintentional injury as a cause of morbidity, death, and significant economic burden and also highlights promising prevention strategies. *The*

reports were compiled by Judy A. Stephens, PhD, MS, MPH, and Christine Branche, PhD, of NCIPC's Division of Unintentional Injury Prevention (DUIP).

Efforts to Increase Smoke Detector Use in U.S. Households: an Inventory of Programs is another DUIP-prepared report. Injury control practitioners throughout the country are focusing on strategies to reduce deaths and injuries from residential fires. Promoting the use of smoke detectors in homes—assuring that people obtain, install, and maintain smoke detectors—is a keystone of most strategies. This report summarizes the approaches used in 49 programs in 33 states and 2 national efforts and gives contacts for additional information. Some of the summaries describes comprehensive programs that incorporate evaluation, and others report on specific smoke detector giveaway programs. *This inventory is based on a 1994 DUIP survey and was compiled by Ruth Shults, RN, MPH, and Pauline Harvey, MSPH.*

Youth Violence Prevention: Descriptions and Baseline Data from 13 Evaluation Projects is a special supplement to the *American Journal of Preventive Medicine.* This publication assembles articles describing data and programmatic activities of 13 youth violence prevention projects throughout the country that were funded under CDC cooperative agreements. Overall, the projects reflect CDC's dual emphasis on scientific analysis and action to stem the compelling problem of youth violence. The demonstration projects use varied strategies, but all have in common strong theoretical foundations, active collaboration with community partners, and carefully planned evaluation. Each article summarizes the project's background, underlying scientific theory, intervention activities, evaluation design, and selected baseline data. Included are overview chapters discussing the issue of youth violence and public health approaches to its prevention. *Guest editors for this supplement are Kenneth E. Powell, MD, MPH, and Darnell Hawkins, PhD.*

Homicide and Suicide Among Native Americans, 1979-1992, the second in the Violence Surveillance Summaries published by NCIPC, underlines the serious threat of violence to Native Americans. During the 14-year period studied, 4,718 American Indians and Alaskan Natives died from violence—about half from homicide and half from suicide. The rates of violence among Native Americans are strikingly higher than the overall U.S. rates: about double the homicide rate and about 1.5 times the suicide rate. Rates of suicide are disproportionately higher among young people, especially males. This report briefly addresses some of the epidemiologic and social characteristics of violence among Native Americans and suggests prevention strategies. *Authors of this report are L. J. David Wallace, MSEH; Alice D. Calhoun, MD, MPH; Kenneth E. Powell, MD, MPH; Joann O'Neil, BS; and Stephen P. James, BS.*

Major Causes of Unintentional Injuries Among Older Persons: an Annotated Bibliography reviews 73 publications on issues related to injuries that affect older people. Gathered in one place are abstracts of articles and books that address injury epidemiology, the extent of unintentional injuries, pedestrian and motor vehicle-related injuries, falls, fires and burns, and poisoning. This publication is a useful resource for injury control practitioners and others concerned with the overall health care of older people. *This bibliography was compiled by Judy A. Stephens, MS, MPH, and Tracey A. Thomas.* ■

CALENDAR

November 19-21 Safe America: Fourth National Injury Control Conference , Washington, DC. Sponsored by CDC's National Center for Injury Prevention and Control, the meeting will highlight effective programs linked to the science of injury control, strengthen partnerships among organizations in the field, and foster communication about injury prevention and control. Contact: Dr. George Roberts, NCIPC (770/488-1441)

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